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Commentary: Lessons from Medicaid—Improving Access to Office-Based Physician Care for the Low-Income Population

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A B S T R A C T

Medicaid offers important lessons about providing access to office-based physician services for the poor. First, differentials in physician fees between Medicaid and other payers compromise access to care and are difficult to reverse. Second, managed care alone is not enough to attain equity in access, especially if differentials in payment rates between Medicaid and private patients in managed care settings are allowed to grow. Finally, financing strategies alone are not sufficient to resolve the shortage of health care providers in medically underserved areas. In these areas, payment policy must be combined with resource development to ensure that vulnerable populations have access to care. (*Am J Public Health.* 1994;84:550–552)

Introduction

As the nation embarks on a sweeping reform of our health care financing and delivery system, it is worthwhile to take a moment to reflect on past experience. There is much to inform the health reform debate from the nearly 3 decades of experience with Medicaid, the nation's health care financing program for the poor. That experience provides valuable lessons on how to organize, pay for, and deliver services to low-income populations as well as on the pitfalls to be avoided.

Medicaid has had considerable success in improving access to medical care for low-income people but has fallen short of its goal to integrate the poor into the mainstream of medical care. Too often, people covered by Medicaid have not had the same level of access to physicians in private office-based practice as have those with private insurance. Instead, the poor have continued to rely on clinics and emergency departments for their care. As Reisinger and her colleagues discuss in this issue,[1] significantly lower payment rates to physicians by Medicaid relative to either Medicare or private insurance are often cited as representing a major contributor to this disparity. Corrective action, now more than ever, is both expensive and politically difficult.

What, then, are the lessons from the Medicaid experience in promoting access, and how can these lessons be applied to our current efforts to reform the health care system?

The Medicaid Experience

Since its enactment, the Medicaid program has made great strides in improving access to health care services for its beneficiaries. Although gaps in access to care remain, today access to medical care for many of the most impoverished and vulnerable of our society is notably better because of Medicaid. Before Medicaid, hospital and physician use rates by the poor lagged considerably behind those of the nonpoor. Since its enactment, many of the differences in medical care related to income have been reversed.[2] The poor with Medicaid now use physicians' services at rates comparable to the nonpoor population, while the uninsured poor have fewer visits.[3]

Despite this progress, Medicaid beneficiaries still face barriers in obtaining some types of services and receiving care in the most appropriate setting. Access to physicians' services is often limited by the availability of physicians willing to accept Medicaid patients and Medicaid payments. A quarter of the nation's physicians report that they will

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Note. The views expressed are the authors', and no endorsement by the Henry J. Kaiser Family Foundation or the Kaiser Commission on the Future of Medicaid is intended or should be inferred.

not accept Medicaid patients in their practices. Roughly a third limit the number of Medicaid patients they will see, and another 5% will not accept any new patients into their practices. Only a third of physicians participate fully in the program.[4]

Participation in Medicaid is a particularly acute problem for pediatricians and obstetrician/gynecologists, whose services are needed by the low-income women and children who constitute the majority of Medicaid beneficiaries. Among pediatricians, a physician specialty that has historically had one of the highest Medicaid participation rates, the percentage of doctors limiting their Medicaid caseloads has grown in the past decade.[5] With one in five children receiving health care coverage through Medicaid, diminishing participation among pediatricians has serious implications for access to care.

Despite the restrictions in access to physicians in private practice, physician's offices are still the prominent site of care for Medicaid beneficiaries. An analysis of the distribution of physician visits by nonelderly Medicaid beneficiaries conducted by the Kaiser Commission on the Future of Medicaid (using the 1987 National Medical Expenditure Survey) shows that 62% of visits occurred in private physicians' offices. This figure, surprisingly high to some, is considerably lower than the 82% for privately insured individuals.

Reduced availability of office-based physicians for Medicaid patients contributes to their greater dependence on institutional providers as a source of care. According to the Kaiser Commission's analysis, Medicaid beneficiaries were about twice as likely (37% vs 17%) as their privately insured counterparts to receive care in institutional settings. For the Medicaid population, clinics (11%) and hospital outpatient departments (15%) provided a quarter of all visits, and emergency departments accounted for 1 in 10 (11%). For privately insured persons, in contrast, clinics, hospital outpatient departments, and emergency departments accounted for 6%, 6%, and 5%, respectively, of all physician visits.

This reliance by the Medicaid population on institutional care has fostered concerns about both the cost and appropriateness of care in these settings. The likelihood of fragmented care, less preventive and primary care, and higher costs has led to Medicaid program initiatives to increase the availability of office-based physicians for its beneficiaries.

The inadequacy of Medicaid payment rates, in comparison with those of Medicaid and private insurance, is often cited as a major factor contributing to low levels of Medicaid participation by physicians. As Reisinger and her colleagues demonstrate, Medicaid fees are substantially lower than Medicare levels and would require considerable new expenditures to bring them into conformity.[1]

Setting payment levels for physicians under Medicaid is fundamentally a matter of state policy. Although Medicaid is jointly financed by state and federal dollars, states have broad discretion over payment mechanisms and levels. Medicaid payments to office-based physicians were 66% of Medicare's prevailing charges in 1990, according to the Physician Payment Review Commission's analysis. For pediatric or obstetric services, traditionally not covered by Medicare, Medicaid fees were about 55% of the rate of private payers.[6] This differential creates a strong incentive for physicians not to take Medicaid patients, especially since they are often sicker and may be more complex to manage than others.

Two major strategies have been proposed to address the access differentials stemming from these policies. One strategy builds improvements on the traditional Medicaid fee-for-service structure. This approach focuses on increasing the pool of participating physicians by enhancing the attractiveness of Medicaid through increased payment levels, reduced billing complexity, improved continuity of coverage, and administrative reforms.

A second strategy uses alternative delivery systems, particularly managed care, to expand access. The managed care approach attempts to provide a more direct connection between payment policy and physician participation. In this approach, physicians are recruited to serve Medicaid patients either as primary care case managers for a defined Medicaid population or as practitioners in organized delivery systems that receive capitated payments for an enrolled population. In primary care case management, enhanced payment levels are often used to induce more physicians to take responsibility for case management. In a capitated system, payments made in advance of service delivery ensure compensation and also reduce hassles associated with fee-for-service billing.

These attempts to improve access for Medicaid enrollees through either the fee-for-service or the managed care approach offer insights for future policy. They can help shape current initiatives to improve access to care for vulnerable populations.

Access Reform Strategies

The costs of making Medicaid fees comparable to Medicare rates in order to shift the care of Medicaid patients from institutional settings to physician's offices are an important consideration. As Reisinger and her colleagues show, just bringing Medicaid fees up to Medicare levels would require an additional $3.23 billion, a nontrivial increase in tight budgetary times. Even a more targeted approach that selectively increases payments for office visits at a cost of $1.12 billion would, as the authors discuss, still fall short of reaching parity with Medicare.

The cost of eliminating differentials between Medicaid and other payers has been a perennial stumbling block to physician payment reform under Medicaid. The outcome of federal legislation (the 1989 Omnibus Budget Reconciliation Act) that put additional pressure on states to boost Medicaid payments to pediatricians and obstetricians requires further evaluation with regard to its effect on expanding access to care.

The recent unprecedented growth in Medicaid spending has dimmed the prospects for raising physician fees. From 1991 to 1992, Medicaid spending grew by 29% and totaled $120 billion in federal and state expenditures. While the 3% increase in Medicaid spending proposed by Reisinger and others to match the Medicare fee schedule would not be a major new escalator of Medicaid spending, it nonetheless represents a substantial new cost. It will be difficult to find resources to increase payments to physicians, no matter how modest or targeted the increase, when all the pressures on the program are to reduce spending.[7]

Moreover, fee increases alone may not be sufficient to eliminate the differentials between Medicaid beneficiaries and the privately insured in access to office-based physicians. For many practitioners, complex administration and unstable eligibility policies make Medicaid

an unappealing payer. Although states have tried to address these problems by simplifying billing, establishing toll free hotlines to answer questions on billing procedures, and expediting payment practices, many physicians still perceive Medicaid as administratively burdensome.[8]

Concerns that repair of the fee-for-service system will not achieve the desired improvements in access and cost control have led many states to shift from traditional fee-for-service to managed care. As of June 1993, 4.8 million Medicaid beneficiaries, approximately 15% of the total Medicaid population, were enrolled in managed care programs in 36 states and the District of Columbia.[9]

While the potential of managed care to improve access to care and overcome the fragmentation of the fee-for-service system holds promise, Medicaid's history with managed care also raises cautions. At the heart of the debate is whether managed care will improve access to care or will instead shift low-income people's care into organizations whose incentives may be to underserve. Evaluations of Medicaid managed care indicate that it can enhance access to basic services but may not offer the savings or quality improvements originally envisioned.[10]

If managed care is to be a viable means of improving access to care for the low-income population, precautions must be taken to prevent the perpetuation or recurrence of the payment differentials that have characterized traditional fee-for-service systems. An attraction of managed care for Medicaid officials is the promise of coordinated services for beneficiaries at a reduced cost. This attraction is also a great potential danger because it provides the incentive to cut costs by underserving enrollees, especially if payments are not sufficient to cover the full costs of services. If the differences between Medicaid and private pay managed care are allowed to grow over time, managed care could result in more access problems than it corrects.

Beyond payment policy and care organization, access to care for low-income populations is highly influenced by the supply of doctors and physician practice locations in low-income areas. The segregation of office-based physicians' offices from low-income areas limits access by Medicaid beneficiaries and by other low-income individuals generally.[11] Regardless of the increases in payments to physicians, administrative simplifications, and system reforms, individuals who now live in medically underserved remote rural areas and destitute pockets of inner cities are likely to continue to reside in such areas. They will continue to need clinics and hospital outpatient and emergency departments to meet their health care needs.

In the design of a reformed system, the consideration of the availability and accessibility of practitioners who serve the poorest and most vulnerable will be as critical as the efforts to reduce payment inequities between practitioners. Health care reform should include provisions to develop adequate resources for low-income medically underserved communities, including public hospitals, community and migrant health centers, and other publicly funded providers.

Conclusions

We have once again reached a crossroads in national health policy. Whether we make sweeping reforms or try to work with the current Medicaid structure to improve access to care, there are three major lessons that we can take from our experiences with the Medicaid program. First, the disparities in physician fee levels between Medicaid and the private sector have compromised access to care for the Medicaid population. Unfortunately, the old adage "You get what you pay for" has too often rung true in the Medicaid experience. Second, managed care alone is not sufficient to equalize the access differences. Moreover, if, over time, the differences between payment rates for Medicaid enrollees and private-sector individuals in managed care settings are allowed to grow, they will become increasingly difficult to reverse. The spending of additional federal or state dollars to increase physician fees is not a popular cause. Third, even if payment rates are equivalent for all payers, bringing payment for care of the poor to parity with privately insured rates, financing alone is not sufficient to resolve the shortage of health care providers in the medically underserved areas where so many of the nation's poor reside. In these areas, payment policy must be combined with resource development to ensure that our most vulnerable populations have access to needed services. □

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